CHAPTER 8

Behavior Problems in Children

Arwa Nasir

The primary care physician's office is often the point of first contact for families who have children with disruptive behavior. Parents seek help for a range of problems in different age groups. Sleeping problems and excessive crying or infantile colic are the two common problems in infancy. School refusal and hyperactive behavior are observed in the early elementary school years. Learning disabilities become evident at the middle to late elementary school years. In the adolescent years, behavioral problems in the form of aggressive behavior and substance abuse are often seen. The observed increase in the incidence of autistic spectrum disorders (ASDs) in recent years and the availability of effective management of this condition makes it important for the primary care physician to have the knowledge and skills to evaluate and refer a child presenting with an ASD.

Although children with behavioral problems often arrive prelabeled, the physician should always be ready to consider alternate diagnoses if the situation warrants it. The physician should also be aware that frequently more than one behavioral problem coexists in the same individual.

A large proportion of behavioral problems is the result of maladaptive interactional patterns within the family. These maladaptive interactional patterns also maintain the problem behavior. Literature indicates strong associations between family attributes, including maternal mental health, parental discord, and parenting behavior, and the diagnosis of many behavioral disorders in children including attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder.

The role of the physician in this situation is to clarify the problematic dynamic in a nonjudgmental fashion, and provide advice or referral for the parent and/or child.

ANXIETY DISORDERS

Anxiety disorders are the most common psychiatric disorders diagnosed in children and adolescence with a prevalence of 7% to 13%. Anxiety disorders can be classified into four different categories: generalized, separation anxiety, social anxiety disorder or social phobia, or obsessive-compulsive disorder.

Symptoms
- Excessive uncontrollable worry that is developmentally inappropriate
- Anxious anticipation
- Causes subjective distress *or* affects social or academic performance
- School refusal
- Somatic symptoms such as abdominal pain

Signs
- Tachycardia
- Diaphoresis
- Pallor or flushing
- Tremor

GENERALIZED

Signs
- Children in this category worry about all manner of upcoming events including school performance, punctuality, and crime and natural disasters.
- They tend to be perfectionists and require excessive reassurance.

OBSESSIVE-COMPULSIVE DISORDER

Symptoms
- Recurrent, time-consuming obsessive or compulsive behaviors that cause distress and/or impairment
- Obsessions are repetitive, intrusive thoughts and impulses.
- The compulsions can be physical behaviors such as handwashing or ritualistic cleaning, or cognitive, such as counting and praying.

Comments and Treatment Considerations
Because fears and worries are common in the pediatric age group, the diagnosis should focus on demonstrating high and developmentally inappropriate intensity and pervasiveness of worry, and disruption of function. Anxiety should be included in the differential diagnosis of children who present with recurrent abdominal pain, headaches, or other somatic symptoms. Medical conditions that produce sympathetic hyperactivity may mimic anxiety symptoms and include hypoglycemic episodes, hyperthyroidism, cardiac arrhythmias, caffeine toxicity, pheochromocytoma, or medication side effects.

Pharmacologic treatment with SSRIs is effective for generalized anxiety disorder, social phobia, and obsessive-compulsive disorder. Cognitive-behavioral therapy and desensitization therapy are probably efficacious for most forms of anxiety.

SEPARATION ANXIETY

Symptoms
- Refusal to sleep alone
- Excessive distress or physical symptoms when separated such as dizziness or palpitations
- Older children and adolescents may present with somatic symptoms such as abdominal pain or headaches.

Signs
- Excessive worry about separation from an attachment figure or place
- Separation anxiety is developmentally appropriate in children younger than 5 to 6 years of age.
- School refusal is the most common presentation of separation anxiety.

SOCIAL ANXIETY DISORDER

Symptoms
- Sweating
- Palpitations
- Tremor
- Flushing or pallor

Signs
- Children have a persistent fear of being humiliated or embarrassed in social situations.
- More common in girls than boys

Workup
- The prognosis for remission depends on the severity and pervasiveness of symptoms and on life events that may reassure the individual or validate and reinforce his or her fears.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

ADHD is a behavioral syndrome defined as the presence of symptoms of inattention, impulsivity, or hyperactivity that are maladaptive and inconsistent with developmental stage. There must be evidence that symptoms compromise social, academic, or occupational function in more than one setting. Evidence of some of the behaviors needs to have been observed before age 7 years and persisted for more than 6 months (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [DSM-IV]). The DSM-IV lists nine behaviors in each of the categories of inattention and hyperactivity. Diagnosis is considered if the child meets six of the

criteria in one or both categories. A child may have a predominantly inattentive or predominantly hyperactive or a combined type ADHD. Symptoms of inattention or hyperactivity that do not cause impairments in learning or social functioning do not meet the criteria for ADHD.

Symptoms

- Inattention and/or impulsivity
- Impairments in learning or occupational function
- Comorbid neuron-developmental conditions such as learning disabilities, ODD, anxiety disorders +++

Signs

- Beginning prior to 7 years of age ++++
- Persisting more than 6 months ++++
- Symptoms occur in more than one setting (e.g., home and school) +++++

Workup

- Impaired social (peer relations) or occupational (school) functioning
- Demonstrated impairment in more than one setting. Frequently obtain input from parents and teachers.
- Several assessment tools that are based on the DSM-IV criteria are available for evaluating children with ADHD. The two most commonly used are the National Initiative for Children's Healthcare Quality (NICHQ) Vanderbilt Assessment and the Conner's Rating Scale Revised. Both include screening questions for comorbid conditions commonly associated with ADHD such as ODD (both) and depression (Vanderbilt).

Comments and Treatment Considerations

Most children who are diagnosed with ADHD are diagnosed during the early elementary school years, when their inattention or hyperactivity interferes with their learning or ability to comply with standards of behavior in the classroom.

The American Academy of Pediatrics (AAP) has published treatment guidelines based on comprehensive evidence-based review of the literature. The AAP guidelines stress the importance of accurate diagnosis and close follow-up and monitoring in addition to the pharmacologic and nonpharmacologic components of the management of the child with ADHD.

The nonpharmacologic component of management includes:

- Educating the family and the child about the nature of the problem and management options. Parent training in behavior management and structuring the environment of the child are helpful.
- Educational management: Identifying possible coexistent learning disabilities, and identifying academic issues that may improve classroom performance, including preferential seating, and one-on-one tutoring.
- Cognitive-behavioral therapy

Pharmacotherapy with stimulant medications has been shown to be effective in decreasing undesired behavior and improving function in the majority of children with ADHD. Monitoring of efficacy and side effects of stimulant medications is imperative. The reader is referred to other sources for a more detailed discussion of the pharmacologic management of ADHD.

AUTISM

Autism is a neurodevelopmental disorder characterized by impairments in three domains:
- Reciprocal social interaction
- Verbal and nonverbal communication
- Range of activities and interests

Autism is a spectrum disorder, which means that it affects children differently. Autistic behaviors can range from mild to severe. The child may be recognized as unusual at birth, or symptoms may first be noted during the first 1 to 2 years of life.

Autism presents as delay in reaching developmental milestones, especially speech. Autistic children also lack normal social interaction with others, including parents, and seem to be "in a world of their own." They also display unusual behaviors including self-stimulation behaviors, limited interest, and repetitive behaviors.

Symptoms
- A child who does not babble, point, or make meaningful gestures by 1 year of age
- A child who does not speak one word by 18 months
- A child who does not combine two words by 2 years
- A child who does not respond to his/her name
- A child who does not seem to know how to play with toys
- Preoccupation with order of things: lines up toys or other objects
- A child who at times seems to be hearing impaired
- Difficulty with emotional regulation: tend to lose control, difficult to console

Signs
- Poor eye contact
- Lack of smile
- Self-stimulating behaviors
- Repetitive behaviors

Workup
- Several screening tools are available to assist the clinician to quickly gather information about the child's social and communicative development, such as the Checklist of Autism in Toddlers (CHAT).
- Once a child is suspected to have autistic features, a comprehensive evaluation by a multidisciplinary team is indicated.

Comments and Treatment Considerations

Several problems are frequently associated with autism: mental retardation, hearing impairment, seizure disorder, and associations noted with some genetic syndromes including fragile X and tuberous sclerosis.

Autistic spectrum disorders are treatable. A wide variety of treatment options can be very helpful. Left untreated, most autistic children do not develop effective social skills and may not learn to talk or behave appropriately.

OPPOSITIONAL DEFIANT DISORDER

The essential feature of ODD is a recurrent pattern of developmentally inappropriate negativistic, defiant, disobedient, and hostile behavior toward authority figures (DSM-IV). These behaviors tend to be more evident with the people the child knows well.

ODD tends to be more prevalent in families in whom parenting is harsh, inconsistent, or neglectful. Current conceptualizations of the disorder focus on maladaptive parent-child interactional patterns. ODD is considered to be the developmental antecedent of conduct disorder, which includes all the criteria of ODD, in addition to more severe violence in the form of physical aggression, destruction of property, deceitfulness, and serious violations of rules.

Symptoms

- Begins around ages 8 to 13 years +++
- Short temper +++
- Stubbornness +++
- Arguing (with adults) +++
- Defying rules and resistance to direction
- Anger and resentment
- Spitefulness and vindictiveness
- Unwillingness to compromise, negotiate, or give in
- Unwillingness to accept responsibility or blame for misdeeds, blaming others
- Verbal aggression

Signs

- Manifests in the preteen to early teen years ++++
- Characteristic behaviors appear in the home setting before extending to other settings.

Comments and Treatment Considerations

Parent training is effective in treating oppositional and defiant behaviors. Parent training programs consist of standardized, short-term interventions to teach parents specific parenting strategies including reinforcement strategies and other behavior modification techniques, in addition to positive parenting and ignoring unwanted behavior. Parent participation is critical to the success of any treatment strategy.

References

American Psychiatric Association: *Diagnostic and statistical manual of mental disorders, fourth edition*, Washington, DC, 2000, APA.

Farley SE, Adams JS, Lutton ME, et al: Clinical inquiries. What are effective treatments for oppositional and defiant behaviors in preadolescents? *J Fam Pract* 54:162,164–165, 2005.

Goldson E: Autism spectrum disorders: an overview, *Adv Pediatr* 51:63–109, 2004.

Greene RW, Doyle AE: Toward a transactional conceptualization of oppositional defiant disorder: implications for assessment and treatment, *Clin Child Fam Psychol Rev* 2:129–148, 1999.

Parker S, Zuckerman B, Augustyn M: *Developmental behavioral pediatrics: a handbook for primary care*, 2nd ed, Philadelphia, 2005, Lippincott Williams & Wilkins.

Reiff MI, Stein MT: Attention-deficit/hyperactivity disorder: diagnosis and treatment, *Adv Pediatr* 51:289–327, 2004.

Yusin AS: American Academy of Pediatrics practice parameter on attention-deficit/hyperactivity disorder, *Pediatrics* 113:428–429, 2004.